APPLICATION FOR RESIDENCY

Please complete the following sections of the application:

Section A: **Personal Information** (one for each applicant)

Section B: **Financial Information** (one per couple)

The following documents must accompany the application for financial approval:

- Copies of **two** most recent tax returns (summary pages)
- Copies of most recent statements for investments (summary pages)
- Market analysis on current value of home

Section C: **Additional Information** (one for each applicant)

Section D: **Physician's Summary** (one for each applicant – Assisted Living only)

- Bring this to your primary care doctor (s) for completion

Please return the application to:

Masonicare at Ashlar Village:	Independent Living (CCRC) *$1,350 application fee* Assisted Living (Pond Ridge)	Marketing Department Cheshire Road P.O. Box 70 Wallingford, CT 06492 203-679-6425
Masonicare at Mystic:	Independent Living Assisted Living	Marketing Department 23 Clara Drive Mystic, CT 06355 860-543-4529
Masonicare at Newtown:	Assisted Living (Lockwood Lodge)	Assisted Living Director P.O. Box 5505 Newtown, CT 06470 203-364-3179
Masonicare Health Center:	Independent Living (Johnson, Hawkins, Wells Apts.)	Admissions Department P.O. Box 70 Wallingford, CT 06492 203-679-5905

Thank you for your interest in residency at Masonicare!

Masonicare

Application for Residency

Please select from the following:

- ☐ **Masonicare at Ashlar Village** — Independent Living (CCRC) / Assisted Living (Pond Ridge)
- ☐ **Masonicare at Mystic** — Independent Living / Assisted Living
- ☐ **Masonicare at Newtown** — Assisted Living (Lockwood Lodge)
- ☐ **Masonicare Health Center** — Independent Living (Johnson, Hawkins, or Wells apartments)

SECTION A – PERSONAL INFORMATION

APPLICANT INFORMATION

Name: ____
Last *First* *Middle* *Maiden*

Address: ____
Street *Unit #* *City*

______________________________ Date of Birth ______/______/______
State *Zip* *Month* *Day* *Year*

Phone: (______)__________________ ☐ Male ☐ Female

Cell Phone: (______)__________________ Religion ____________________

Email: ______________________________ Church ____________________

Marital Status: ☐ Married ☐ Single ☐ Widow/Widower

Spouse Name: ______________________________ Date of Spouse's Death: ______________

PERSON TO NOTIFY IN CASE OF EMERGENCY

Primary Contact:

Name: ______________________________ Relationship: ____________________

Address: ____

Home: (_____)______________ Cell: (____)______________ Work: (_____)______________

Email: ______________________________

Secondary Contact:

Name: ______________________________ Relationship: ____________________

Address: ____

Home: (_____)______________ Cell: (____)______________ Work: (_____)______________

Email: ______________________________

Masonicare

SECTION A – PERSONAL INFORMATION

ADVANCE MEDICAL DIRECTIVES

Do you have a **Living Will**? ☐ Yes ☐ No **(Please attach a copy)**

Do you have a **Power of Attorney**? ☐ Yes ☐ No **(Please attach a copy)**

Name: ______________________ Phone: (______) ______________________

Address: ____

Do you have a **Health Care Agent/Representative**? ☐ Yes ☐ No **(Please attach a copy)**

Name: ______________________ Phone: (______) ______________________

Address: ____

Do you have a **Conservator or Guardian**? ☐ Yes ☐ No **(Please attach a copy)**

Name: ______________________ Phone: (______) ______________________

Address: ____

What is his/her relationship to you? ______________________________

INSURANCE INFORMATION

Primary Medical/Medicare Insurance **(Please attach copy of card)**

Company Name: ______________________ Policy# ______________________

Address: ____

Secondary Medical Insurance **(Please attach copy of card)**

Company Name: ______________________ Policy# ______________________

Address: ____

Prescription Insurance **(Please attach copy of card)**

Company Name: ______________________ Policy# ______________________

Address: ____

Long-Term Care Insurance **(Please attach copy of card)**

Company Name: ______________________ Policy# ______________________

Address: ____

Soc. Sec. #: ______________________ Are you eligible for Medicare? ☐ Yes ☐ No

Medicare #: ______________________

Masonicare

Name(s): ______________________________

Assets:

Real Estate	$______________
Other Real Estate	$______________

Savings and Investments:	**Current Balance**	**Survivor**
Cash/Checking Accounts	$______________	%________
Savings/CDs	$______________	%________
Money Market Accounts	$______________	%________
Stocks/mutual funds	$______________	%________
Bond/bond funds	$______________	%________
Life Insurance	$______________	$ ________

TOTAL ASSETS: $______________

Liabilities:

Mortgage	$______________
Other	$______________

TOTAL LIABILITIES: $ ______________

TOTAL NET WORTH: $ ______________

Net Monthly Income:	*Person 1*	*Person 2*
Social Security	$__________	$__________
Pension/retirement	$__________	$__________
Other	$__________	$__________

TOTAL MONTHLY INCOME: $ ______________

Masonicare

Long-Term Care Insurance

Do you have Long-Term Care Insurance? Yes ☐ No ☐
If yes, please complete the following:

	Person 1	*Person 2*
Benefit Period (Time limit on payments) (Generally – 1, 2, 5 years or lifetime)	____________________	____________________
Elimination Period – Waiting time before payments start (ex. 30, 60, 90 days)	____________________	____________________
Daily benefit in Assisted Living	$ ____________________	$ ____________________
Annual Premium (current dollars)	$ ____________________	$ ____________________

I (we) hereby agree, upon approval of my (our) application, to make no changes in my (our) financial status that will prevent me (us) from providing my (our) own financial needs while residents.

I (we) declare that all statements made in this application are full, true and correct.

Signature:____ ***Date***:______________________
Person 1

Signature:____ ***Date***:______________________
Person 2

Masonicare

SECTION C – ADDITIONAL INFORMATION

Military

Are you a military veteran? ☐ Yes ☐ No

Is/was your spouse a military veteran? ☐ Yes ☐ No

What is your claim number? ____________________ Your spouse's? ____________

Masonic Affiliation

Are you or any member of your family a member of a Masonic organization? ☐ Yes ☐ No

What is the name and relationship of that family member? ____________________

What Lodge/Chapter/Court do you belong to? ____________________

General Information

Applicant's occupation: (If retired, please indicate this and give former occupation.)

____

Employed by (last or present employer): ____________________ Number of years employed:_______

The information supplied is accurate to the best of my knowledge.

I fully understand that any acceptance for residency at Masonicare is contingent upon my meeting all requirements set by the Board of Directors of Masonicare and there being an accommodation available and agreeable

____________________________________ ______________

Signature Date signed

This page left intentionally blank for double side copying.

Masonicare

SECTION D – PHYSICIAN'S SUMMARY

Note to Physician: The person whose name appears below is an applicant for admission to Masonicare. A current health report *is required* as part of the admission process.

Applicant's Name: ______________________

Date of Birth: __________ Age: __________ Sex: Male ☐ Female ☐

Address: ______________________

City/State/Zip: ______________________

Please complete this form and send to: (check one)

Masonicare at Ashlar Village	Masonicare at Mystic	Masonicare at Newtown	Masonicare Health Center
Independent/Assisted Living	*Independent/Assisted Living*	*Assisted Living*	*Johnson/Hawkins/Wells Apts.*
Marketing Department	**Marketing Department**	**Assisted Living Director**	**Admissions Department**
P.O. Box 70	23 Clara Drive	P.O. Box 5505	P.O. Box 70
Wallingford, CT 06492	Mystic, CT 06355	Newtown, CT 06470	Wallingford, CT 06492
Tel: 203-679-6425	Tel: 860-543-4529	Tel: 203-364-3179	Tel: 203-679-5901
Fax:203-679-6044 ☐	Fax:860-572-0021 ☐	Fax:203-364-3299 ☐	Fax:203-679-6900 ☐

Purpose of Assessment: ☐ Pre-Admission Date of Examination: __________

Primary diagnosis + ICD-9 code: ______________________

Secondary: + ICD-9 code: ______________________

☐ PPD ☐ Chest X-Ray Date Received: __________ Result: ☐ None/Inactive ☐ Active/Quiescent

If contraindicated, state reason: ______________________

Physical Health:

Weight __________ Height __________ Blood Pressure __________

Pulse __________ Respiration __________

Functional Abilities:	Good	Fair	Poor	Additional Information
Walking (with/without device)	☐	☐	☐	__________
Hearing (with/without device)	☐	☐	☐	__________
Vision (with/without corrective lenses)	☐	☐	☐	__________
Speech	☐	☐	☐	__________

Activities of Daily Living:	Self	Assistance Required	Additional Information
Bathing	☐	☐	__________
Personal Hygiene	☐	☐	__________
Dressing	☐	☐	__________
Toileting/Toilet Hygiene	☐	☐	__________
Transferring (bed to chair/chair to bed)	☐	☐	__________
Oral Hygiene/Denture Care	☐	☐	__________
Eating at meal time	☐	☐	__________

Medication Use:	Yes	No	Additional Information
Does resident administer own medications?	☐	☐	____________
Does resident require medication reminder?	☐	☐	____________
Does resident require supervision when taking medications?	☐	☐	____________

Lifestyle:	Yes	No	
Does the resident smoke?	☐	☐	____________
Does the resident consume alcohol?	☐	☐	____________

Mental Health:

Cognitive Status ☐ Alert ☐ Short-term memory concerns
☐ Confused ☐ Long-term memory concerns

Evidence of Dementia ☐ Yes ☐ No Type if known: ____________

History of Mental Illness/Health Problems: ☐ Yes ☐ No

Diagnosis, if known ____________

Medical History: *If yes, give details. Use additional sheet if necessary.*

Condition	Yes	No	Condition	Yes	No
Arthritis	☐ Yes	☐ No	Hematological Disorders	☐ Yes	☐ No
ASHD	☐ Yes	☐ No	Hepatic Pathology	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Cerebral Arteriosclerosis	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No
Cerebral Vascular accident	☐ Yes	☐ No	Neurological Disease	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Developmentally Disabled	☐ Yes	☐ No	Pancreatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pulmonary Disease	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No	Renal Pathology	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Family or other history of HIV	☐ Yes	☐ No	TBC	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No			

Other: ____________

Details: ____________

____

Allergies: ☐ Yes ☐ No Explain: ____________

Review of Systems:

Integumentary

Respiratory

Cardiovascular

Gastrointestinal

Genitourinary

Musculoskeletal

Neurological

Endocrine

Pain

Prescription Medications:

Medication	Dosage	Frequency by time	Additional Information

OTC Medications:

Medication	Dosage	Frequency by time	Additional Information

Other Supplements/Treatments: (i.e. Holistic/Natural/Homeopathic/Massage etc.)

Medication	Dosage	Frequency by time	Additional Information

Special Treatments and Procedures, not listed above (Narrative):______________________________

____

____

Routine Orders:

Routine Lab Work ☐ Yes ☐ No

Test(s) ______________________ Frequency ______________________

Test(s) ______________________ Frequency ______________________

Test(s) ______________________ Frequency ______________________

Podiatry Services ☐ Yes ☐ No Frequency ______________________

Annual Flu Vaccine ☐ Yes ☐ No Date last received ______________________

Other ____

Specific Diet Requirements ☐ Regular ☐ No added salt ☐ Diabetic

☐ Other ____

IMPORTANT

In your medical opinion, is the resident considered chronic and stable? ☐ Yes ☐ No

Does the applicant have a signed Do Not Resuscitate Order (DNR)? ☐ Yes ☐ No

Would you recommend the applicant for a campus-sponsored fitness program? ☐ Yes ☐ No

Are there any restrictions to consider?

Explain: ____

Physician's Name ______________________ *(type or print)*

Physician's Address ______________________ City/State/Zip ______________________

Telephone/FAX ______________________

Signature of Physician______________________ Date ______________________

AUTHORIZATION FOR RELEASE OF MEDICAL

I hereby authorize the release of medical information contained in the report of the examination of:

Applicant Name:____

Signature: ______________________ **Date:** ______________________